STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

Annual Plan Claims Payment and Dispute Resolution Mechanism Report

Plan types in their file number and Plan name & address autofill

Auto Select both Years Reporting Period

1 Plan File Number __ _____

October 1, Sept. 30

2 Plan Name _____
Address _____
_____
_____

3.Designated Principal Officer _____
E-mail _____
Phone Number _____

4. Survey Preparer _____
E-Mail _____
Phone Number _____

5. Claims Payment Compliance Status Portion

(1) Annual Claims Payment Report Tables I.

6. Dispute resolution - summary of information

(1) Plan's summary of disposition of all provider disputes and resolutions.
(2) Delegated groups summary of disposition of all provider disputes and resolutions.
(3) Corrective Actions Report for Plan or delegated groups not meeting resolution deadlines.

7. Plan Verification

A. I certify (or declare) that I have read and reviewed the above-referenced Annual Plan Claims Payment and Dispute Resolution Mechanism Report and all attachments thereto and know the contents thereof, and that the statements therein are true and correct to the best of my knowledge and belief.

_____ _____

Date Designated Principal Officer

Annual Claims Settlement Practices Report – Part II
Reporting Period_____
Plan Name _____
File Number _____

Timeliness Table: **Submit for each Capitated Provider that pays claims (capitated provider) or Claims Processing Organization.**

RBO/Capitated Provider # _____

		Quarter Ending Dec. (Blank for 2005 report)	Quarter Ending March	Quarter Ending June	Quarter ending Sept
1.	Number of Claims paid, denied, adjusted or contested				
2.	Total Number of those claims paid, denied, adjusted or contested within 45 working days or less (Full Service Plans)				
3.	Percent meeting 45 working day standard (Full Service Plans)	(% Auto - calculated)	(% Auto-calculated)	(% Auto-calculated)	(% Auto-calculated)
4.	Total Number of those claims paid, denied, adjusted or contested within 30 working days or less (Specialized Plans, PPOs)				
5.	Percent meeting 30 working day standard (Specialized Plans, PPOs)	(% Auto - calculated)	(% Auto-calculated)	(% Auto-calculated)	(% Auto-calculated)
6.	Days Receipts on hand @ quarter end (FN3)				

(FN3) Payors when calculating DROH at the end of a quarter may use the last Friday of the Quarter or the last calendar day of Quarter so long as the payor reporting is consistent quarter to quarter.

Annual Claims Payment Report – Part II
Reporting Period_____
Plan Name _____
File Number _____

Indicate any corrective action that the Plan has instituted

- ❑ Corrective action plan requested
- ❑ Required additional training
- ❑ Required additional staffing
- ❑ Plan performed more frequent monitoring
- ❑ Enrollment freeze
- ❑ Breach Notice
- ❑ Bi-weekly reporting
- ❑ Weekly Reporting
- ❑ Plan Monitor placed
- ❑ Contracted with additional payors
- ❑ De-delegated claims processing
- ❑ Provider notice to terminate contract
- ❑ Plan terminated contract – Effective Date _____
- ❑ Other (Specify)

  _____
  _____
  _____
  _____

- ❑ No Action Taken

Annual Plan Claims Payment & Dispute Resolution Mechanism Report

1. Plans Summary of disposition of all provider disputes and resolutions the Plan processed: Reporting Period Oct. 1 – Sept. 30

	Total Disputes Submitted	Resolved in favor of Payor	Resolved in favor of provider	Pending Resolution	Resolved within 45 working days	Resulted in Written Determination	Number of Disputes with Interest/Penalties
Claims/Billing	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)
Professional							
Institutional							
Other							
Contract							
UM/Medical Necessity							
Other							

Total Disputes All Providers	Total Disputes Resolved in 45 Working Days	Total Disputes Resulting in Written Determination
(Calculated)	(Calculated)	(Calculated)

Note: Initial Report due Jan. 15, 2005 shall include disputes related to claims for services rendered on or after Jan. 1, 2004.

Annual Plan Claims Payment & Dispute Resolution Mechanism Report

2) For each Capitated Provider that pays claims: Summary of disposition of all provider disputes and resolutions processed by the capitated provider under all capitated arrangements regardless of plan: Reporting Period Oct. 1- Sept. 30

RBO/Capitated Provider _____ Name (Auto-fill)_____

	Total Disputes Submitted	Resolved in favor of Payor	Resolved in favor of provider	Pending Resolution	Resolved within 45 working days	Resulted in Written Determination	Number of Disputes with Interest/Penalties
Claims/Billing	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)	(Calculated)
Professional							
Institutional							
Other							
Contract							
UM/Medical Necessity							
Other							

Total Disputes All Providers (Calculated)

Total Disputes Resolved in 45 Working Days (Calculated)

Total Disputes Resulting in Written Determination (Calculated)

Note: Initial Report due Jan. 15, 2005 shall include disputes related to claims for services rendered on or after Jan. 1, 2004.